DEF EXHIBIT H

IOWA INTERSTATE RAILROAD, LTD.

REPORT OF PERSONAL INJURY OR ILLINESS

EXHIBIT 3 12/5/07 AWJ

PENGAD 800-631-6989

RULE 1.2. GENERAL CODE OF OPERATING RULES: "All cases of personal injury while on duty or on Company property must be immediately reported to the proper manager and the prescribed form completed. A personal injury that occurs while off duty that will in any way affect employee performance must be reported to the proper manager as soon as possible. The injured employee must also complete the prescribed form before returning to service."

Instructions: Answer all questions in each applicable section, ledibly, in ink, accurately and fully in your own handwriting as soon as possible after an accident / illness occurs. If unable to complete the report due to your physical condition, the required information must be furnished by the person completing the form on your behalf.

SECTION I - IDENTIFICAITON OF ILL / INJURED EMPLOYEE

(1) Name of Injured / Ill Person (first, middle, last)	(2) Residence Phone #	(3) Age	(4) Birth Date
Michael L Smock	(563) 649-2230	40	6-29-65

(5) Complete Address (number, street, city, state, zip code): 2141 Hwy #6 Atalissa Iowa 52720

(6) Social Security Number	(7) Employee Number	(8) Gender (circle one)	(9) Marital Status (circle one)
484-84-2036	662	(Male) Female	(Single) Married Divorced Widow/Widower Legally Seperated

(10) Occupation	(11) Department	(12) Date Entered Service
Conductor	Tie	9-9-97

(13) Immediate Supervisor	(14) Time Shift or Trip Began	(15) Assigned Rest Days
	0800	Saturday- Sunday

SECTION II - DETAILS OF ACCIDENT / INCIDENT / ILLNESS

(1) Date of Accident / Incident / Illness	(2) Time	(3) Location (street, track, building, etc) City, State, Zip Code County
11-1-05	1524 (AM) (PM)	oxford elevator oxford Ia

(4) Mile Post 257.6 Division 3 Main Track or Yard

(5) Was Injured / Ill Party (circle one) On Duty Off Duty On Company Property Off Company Property

(6) Weather (Clear) Rain Sleet/Hail Temperature 56° Snow Fog Cloudy Other (explain) _____

(7) Visibility (circle one) Dawn (Daylight) Dusk Dark Artificial Lighting Other (explain) _____

(8) Names and Occupations of Others on Crew or in Department

Bill Mefford engineer

(9) Explain Specific Job or Activity Being Performed at the Time of Accident / Incident / Illness

clear main line to meet east bound.

(10) Describe In Detail How Accident / Incident / Illness Occurred and What Specifically Caused the Accident / Incident / Illness

walking away from switch to watch elevator loading shute.

(11) Did IAIS Equipment and /or Tools Cause or Contribute to the Cause of the Accident / Incident / Illness? (circle one) Yes No

If Yes, Provide Complete Details

Ballast around switch stand area improperly maintained - 8"-12" drop off with loose Ballast. ties not properly dressed higher then the loose ballast.

Continued on back

SECTION II - (continued)

(12) Did Other Persons Cause or Contribute to the Cause of the Accident / Incident / Illness? (circle one) Yes (No)

If Yes, Provide Names of Other Persons and What They Were Doing to Cause or Contribute to the Cause of the Accident / Incident / Illness

(13) List Names, Occupations and Address of All Persons Who Witnessed the Accident / Incident / Illness

SECTION III - TRAIN OPERATION EQUIPMENT INVOLVED IN ACCIDENT / INCIDENT / ILLNESS

(1) Train Symbol	(2) Engine Number	(3) Consist (loads, empties, tons)	(4) Identifying Initials & Numbers of Engine, Car or Other Equipment Involved in Accident / Incident
0800 Dsy	602	0	602 IAIS

(5) Equipment Was (Stopped) Moving - Speed _____ Time Table _____ Direction _____

(6) Did this Accident / Incident / Illness Result from Riding On, Boarding, or Alighting From, or Being Struck or Run Over By Moving Engines, Cars, Cars Lading or Other Equipment? (circle one) Yes (No) If Yes, Explain

SECTION IV - NATURE OF INJURY / ILLNESS AND TREATMENT

(1) Nature of Injury / Illness (laceration, bruise, sprain, etc)

(2) Are of Body Affected (right, left, front, back, upper, lower, etc)

(3) Nature and Extent of Injury / Illness

(4) Treatment Required (circle one) None First Aid Treated & Released X-Rays Hospitalized Other (explai

(5) If First Aid Was Administered, Name the Person(s) and What Type of First Aid Was Administered

(6) Was Injured / Ill Party Examined by a Doctor? (circle one) Yes No If Yes, Doctor's Name/Adress

(7) Doctor's Telephone # ( ) -

(8) What Type of Treatment Was Provided?

(9) Did You Receive a Prescription for the Injury / Illness? (circle one) Yes No

If Yes, Wah is the Name of the Prescribe Medicalton(s)?

(10) If Hospitalized, Name and Address of Hospital

(11) Were You Able to Return to Work on Next Assignment? (circle one) Yes No

If No, Approximate Date of Return

(12) Name of Immediate Supervisor on Duty at the Time of the Injury / Illness

MEDICAL RECORDS AUTHORIZATION

I, the injured / ill person, authorized the health care provider(s) and / or hospital(s) to furnish medical data concerning my injury / illness for as long as I am being treated for this injury / illness to Iowa Interstate Railroad, Ltd., and / or its representatives upon request. I also authorize IAIS and its representatives to talk with the health care provider(s) and / or hospital(s) concerning my injury / illness for as long as I am being treated for this injury / illness. A photostatic copy of this authorization whall be deemed by any health care provider and / or hospital effective and valid as the orginal.

I certify that the foregoing information is true and correct.

Signature of Injured / Ill Person

Person Completing the Report

11-1-05
Date

Distribution of this Report Orginal to the Human Resources Department
Fax to Dispatcher Immediately